Exhibit D

Declaration of Dr. Andrew Clark

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MICHIGAN

CATHOLIC CHARITIES OF JACKSON, LENAWEE AND HILLSDALE COUNTIES, ET AL.,

Plaintiffs,

v.

GRETCHEN WHITMER, ET AL.,

Defendants.

Civil No. 1:24-cv-718

DECLARATION OF DR. ANDREW CLARK

TABLE OF CONTENTS

I, Dr. Andrew Clark, pursuant to 28 U.S.C. § 1746, state and declare:

1. I am over eighteen years of age and fully competent to make this declaration.

I. Credentials and Experience

2. I am a specialist in Child, Adult, and Forensic Psychiatry and am currently in full time private practice in Cambridge, Massachusetts. I started my private practice in 1996, about twenty-eight years ago.

3. I hold a medical degree from the University of Michigan Medical School. After earning my M.D. in 1986, I served as a Resident in Family Practice at San Francisco General Hospital for one year. Thereafter, I spent three years as a Resident in Pediatrics at Boston City Hospital, and then another three years as a Resident in Psychiatry in Massachusetts General Hospital in Boston. The next two years I served as a Resident in Child and Adolescent Psychiatry at Massachusetts Hospital, and I then earned a post-graduate certificate in Infant Parent Mental Health at the University of Massachusetts.

4. I have been board certified in Psychiatry for twenty-nine years; in Child and Adolescent Psychiatry for twenty-eight years; and was certified for six years in pediatrics. Since 2016, I have held a subspecialty certification in Forensic Psychiatry.

5. I am also a member of the American Academy of Child and Adolescent Psychiatry; the American Academy of Psychiatry and the Law; and the Massachusetts Medical Society.

6. I also serve as an Assistant Professor of Psychiatry at Boston University School of Medicine. From 1996-2016, I was a part-time instructor in psychiatry at Harvard Medical School and a clinical associate in psychiatry at Massachusetts General Hospital.

7. Throughout my career, I have served in various capacities at medical practices in Boston. This includes sixteen years as the Director of Psychiatric Services at the South Bay House of Correction in Boston; two years as a trainer for incoming social

workers at the Department of Children and Families and at Family Mental Health; five years at the Director of Medical Student Education in the Department of Psychiatry at Boston University School of Medicine; three years as the attending psychiatrist at the Boston Medical Center; and two years as the Chief of Outpatient Psychiatry at the Boston Medical Center. I also served seven years as the Medical Director of the Children and the Law Program at Massachusetts General Hospital, four years as the Medical Director of the Children's Charter Trauma Clinic in Waltham, Massachusetts, and six years as a case reviewer for the Massachusetts Board of Registration in Medicine in Wakefield, Massachusetts. I also served as the Designated Forensic Psychiatrist for the Massachusetts Department of Mental Health from 1995-2002.

8. I have served in various mentoring and supervisory capacities since 1996, including supervising child psychiatry fellows at Massachusetts General Hospital and Harvard Medical School. I also supervised a psychiatry resident at Boston Medical Center for seven years.

9. My scholarship includes several peer-reviewed articles, reviews, and textbook chapters on issues related to child psychiatry.

10. In private practice, I have counseled and continue to counsel adolescents that are gender nonconforming or struggling with issues related to sexuality and gender identity.

11. My CV is attached as Exhibit 1.

12. I have been asked by Plaintiffs to opine regarding *Catholic Charities of Jackson, Lenawee and Hillsdale Counties v. Whitmer*, No. 1:24-cv-00718, a legal action challenging Michigan HB 4616 and HB 4617, which prohibit mental health professionals from engaging what the state defines as "conversion therapy" with a minor.

13. The opinions I express in this declaration are based on my education, training, experience, and ongoing familiarity with medical literature. These opinions are my own and do not represent the opinion of any professional or other group. They are

also open to change based on advances in the medical literature and the receipt of additional relevant information.

II. Caring for Transgender-Identified Youths

A. Introduction to Gender Identity

14. The medical literature on gender identity, transgender identification, and gender dysphoria typically differentiates between the terms "sex" and "gender." *Sex* in this context refers to the biological classification of an individual as male or female according to reproductive organs and the chromosomal complement (XX for female, XY for male).

15. *Gender* in this context refers to an individual's subjective and personal experience of identification with a particular sex-based role. It is the product of an individual's discernment, and there are no established tests or markers to indicate someone's gender.

16. Gender identity can be that of a man or a woman (a boy or a girl in the case of youths). A *non-binary* gender identity refers to a gender identity which does not conform to that dichotomy. Gender identity is variously conceptualized as either fixed or fluid, and an individual's developing understanding of their gender identity is often described as a process of self-realization. For example, one prominent psychiatrist and researcher described gender identity as a "transcendent sense of gender" that goes beyond language, is hard to describe in words, is highly personal, and presents with "dramatic variability."[1]

17. *Transgender* identification is described as representing a discordance between a person's internal sense of their gender and their physically sexed body.

[1] Jack Turban, *I'm a Psychiatrist. Here's How I Talk to Transgender Youth and Their Families About Gender Identity.*, N.Y. Times (July 8, 2024), https://perma.cc/VY82-JWVW.

Gender dysphoria refers to the subjective and sometimes intense distress that may accompany this discordance.

18. Transgender-identified youths are a highly vulnerable population.

19. Transgender-identified adolescents exhibit very high rates of mental health conditions such as depression, anxiety, eating disorders, post-traumatic stress disorder, attention deficit disorders, substance use disorders, and Autism Spectrum Disorders.[2]

20. Transgender-identified adolescents also have high rates of suicidal ideation and self-harming behaviors, although rates of suicide in transgender adolescents are not elevated when controlling for co-morbid psychiatric conditions.[3]

21. In addition, transgender-identified teenagers experience high rates of family rejection, homelessness, juvenile justice involvement, and involvement in high-risk sexual behavior.

22. Many transgender-identified children and teens experience a significant degree of social stigma.

---

[2] Natalie M. Wittlin et al., *Mental Health of Transgender and Gender Diverse Youth*, 19 Ann. Rev. Clinical Psych. 207, 210-212 (2023), https://perma.cc/868B-XF59; Tracy A. Becerra-Culqui et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers*, 141 Pediatrics (2018), https://perma.cc/U2XX-XG7S; Christian J. Bachmann et al., *Störungen der Geschlechtsidentität bei jungen Menschen in Deutschland: Häufigkeit und Trends 2013–2022* [*Gender identity disorders among young people in Germany: prevalence and trends, 2013–2022. An analysis of nationwide routine insurance data*], 121 Deutsches Ärzteblatt [German Med. J.] 370, 370 (May 31, 2024) (Ger.), https://perma.cc/X5X8-MG4E, *translated via Google Translate*, https://perma.cc/6LPG-XWBV, *official English translation forthcoming*, https://www.aerzteblatt.de/int/archive/article/239563.

[3] Sami-Matti Ruuska et al., *All-cause and suicide mortalities among adolescents and young adults who contacted specialised gender identity services in Finland in 1996–2019: a register study*, 27 BMJ Mental Health, 3-4 (Feb. 17, 2024), https://perma.cc/A5WN-47F4; Michael Biggs, *Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom*, 51 Archives of Sexual Behav. 685, 687-88 (2022), https://perma.cc/77EF-YY3P.

23. For transgender-identified youths, as for all youths in the United States, accessing affordable mental health services is often very difficult.

24. Having a non-conforming gender identity is not considered to be a mental illness.

25. Gender dysphoria, however, involves clinically significant distress or impairment in important areas of functioning. Effective therapy and support are essential for transgender adolescents.

26. There is a significant, ongoing debate in the medical community about what constitutes the most effective therapy and support for transgender adolescents. The debate falls broadly into two different approaches described more fully below: (1) the cautious approach; and (2) the gender-affirming approach.

B. Cautious Approach

27. The cautious approach begins with exploratory therapy, which has long been the prevailing approach for transgender-identified youths. Exploratory therapy is characterized by a recognition of the complexity of human motivations and the challenges that people encounter in truly knowing themselves, as well as a deep respect for the values and goals of the individual patient.

28. In exploratory therapy, the therapist is open minded as to the outcome of the treatment. Rather than seek a particular goal, the therapist strives to help patients develop emotional lives of coherence and depth.

29. Therapists who work with children and teenagers typically utilize a conceptual framework centered around the dynamic process of growth and development. They see the adolescent years as a time of active identity development and exploration. They strive to promote a wide latitude for a teen's exploration, without insisting on a premature commitment to a particular developmental path. Indeed, such therapists are typically vigilant regarding what might be called "developmental dead

ends"—paths that prove at some point to be inhospitable to further psychological growth.

30. Traditionally, the medical profession's approach to individuals who experience discordance between their psyche and their bodies was to attempt to mitigate the distress associated with such discordance by psychotherapy as well as treatment of any underlying conditions, and to avoid medical and surgical intervention.

31. In that spirit, the traditional approach to gender diverse youths had been a cautious one, often referred to as the "watchful waiting" approach, in which children and teenagers were provided therapy and support for an extended period prior to initiating irreversible medical interventions.

32. The watchful waiting approach has been informed by research indicating that the substantial majority of children with a prepubertal transgender identification, up to 80-95%, will desist (*i.e.*, no longer experience gender dysphoria) by the time they have completed puberty and that many of these youths will grow to become cisgender young adults with a homosexual orientation.[4] For many transgender identified children, as for children in general, the process of going through puberty brings with it a greater degree of self-awareness and a consolidation of identity.

---

[4] Peggy T. Cohen-Kettenis et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892, 1893 (2008), https://perma.cc/75GQ-483Z ("estimates range from 80–95%"); Devita Singh et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 21 Frontiers in Psychiatry, 8 (Mar. 2021), https://perma.cc/5JUL-AU6F (87.8% desistence); Bachmann, *supra* note 2, at 370-71; Rittakerttu Kaltiala-Heino et al., *Gender dysphoria in adolescence: current perspectives,* 9 Adolescent Health, Med., & Therapeutics 31, 33 (2018), https://perma.cc/84D8-MDNR ("Evidence from the 10 available prospective follow-up studies from childhood to adolescence (reviewed in the study by Ristori and Steensma) indicates that for ~80% of children who meet the criteria for GDC, the GD recedes with puberty."); *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: DSM-5* at 455, American Psychiatric Association (2013), https://perma.cc/2SL2-HV3D ("Rates of persistence of gender dysphoria from childhood into adolescence or adulthood vary. In natal males, persistence has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%.").

33. An extended assessment process, attention to co-occurring mental health difficulties, and, in some cases, ongoing exploratory therapy were typically considered to be essential elements of optimal treatment of transgender-identified youths.

34. The American Psychological Association 2015 Guidelines for Psychological Practice With Transgender and Gender Non-Confirming People delineated what at the time was considered the appropriate role for mental health professionals.[5]

35. The APA "encouraged" psychologists to "carefully reflect on their personal values and beliefs about gender identity development" and to "keep the best interest of the child or adolescent at the forefront of their clinical decisions at all times."[6] To that end, and "[b]ecause gender nonconformity may be transient for younger children in particular, the psychologist's role may be to help support children and their families through the process of exploration and self-identification."[7]

36. The Guidelines noted that gender nonconformity may be transient for young people. It recommended moving slowly and cautiously in situations of "late-onset gender dysphoria."[8] It suggested that adolescents and their families may need support in tolerating ambiguity and uncertainty. It stressed emphasizing to parents "the importance of allowing their child the freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point… ."[9]

37. It also suggested that mental health problems could complicate assessment and intervention of gender related concerns. It suggested that the presence of Autism

---

5 American Psychological Association, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*, 70 Am. Psych. 832 (Dec. 2015), https://perma.cc/W787-NSYW.

6 *Id.* at 843.

7 *Ibid.*

8 *Ibid.*

9 *Ibid.*

Spectrum Disorder could complicate a young person's articulation and exploration of gender identity.[10]

38. The Guidelines show that a cautious approach was historically preferred.

39. Careful therapists who work with transgender-identified youths often find themselves in a gatekeeper position, as a formal mental health clearance is frequently a prerequisite for medical or surgical intervention.

40. In addition, therapists in that role typically integrate the parents' perspectives and concerns into their treatment planning, including situations where the parents have reservations regarding medical or surgical interventions.

41. As such, the therapist of a transgender-identified youth may exercise an unusual degree of influence in decision-making regarding whether and when to proceed with medical interventions.

42. Many therapists who work with transgender-identified youths will be curious as to the possibility of alleviating their patients' distress through a therapeutic approach rather than a medical one—not because there is anything wrong with being transgender, but because the costs and risks of interventions are so high, the decisions largely irreversible, and the unknowns so great.

43. Many therapists also see an adolescent's simple statement of transgender identification as the product of a psychologically complex process that bears scrutiny and exploration.

44. As an example, therapists who work with transgender teenagers often report elements of internalized homophobia in their patients—the idea that it is more acceptable to be a heterosexual trans person than a homosexual cis person.

---

[10] *Id.* at 845.

45. Additionally, therapists often report cases of females who have experienced sexual harassment or abuse and who seek an identification as a male in part for a sense of safety and empowerment.

46. Therapists who work with adolescents find them at times to be impatient, impassioned, and importunate, and often see their work as that of trying to add an element of reflection and patience to the teenager's sometimes rash decisions.

47. Therapists see children and adolescents as engaged in an active, healthy process of identity development and exploration, and recognize that a young person's heartfelt expression may morph dramatically over time.

48. Therapists who work with teenagers often recognize the exceptional power of peer influences and seek to explore the role of social factors in the child's expression of transgender identification. In recent years they observed that the explosion of trans-identified youth has coincided with increasing social media use.[11]

49. Therapists who work with teenagers recognize that co-occurring mental health conditions can have a substantial impact on the youth's perception, judgment, and self-regard, and seek to untangle the impact of those conditions from the transgender identification.

50. There are many clinical presentations that are complex or concerning enough that a reasonably careful therapist would likely harbor serious reservations about the wisdom of rapidly initiating irrevocable interventions. These might include:

- Cohorts of friends developing a trans identification concurrently;
- Families with multiple transgender siblings;
- Adolescents with a history of psychosis;

---

[11] Lisa Littman, *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*, PLOS ONE, 20-22 (Aug. 16, 2018), https://perma.cc/6TNW-SVKL, *updated on different grounds*, *Correction: Parent reports of adolescents and young adults perceived to show signs of rapid onset of gender dysphoria*, PLOS ONE (Mar. 19, 2019), https://perma.cc/63E7-KWRA.

- Teenagers with moderate or severe symptoms of Autism Spectrum Disorder;
- Persons with dissociative identity disorder (formerly known as multiple personality disorder) or severe post-traumatic stress disorder;
- Teenage boys seeking castration because they identify as a eunuch;
- Youths with severe developmental delay and cognitive limitations;
- Individuals with unrealistic expectations about the transformation of their personalities through medical or surgical interventions;
- Teenagers who place a high value on having children of their own at some point in their future, and who may not appreciate the threat that intervention poses to their fertility.

51. For all these reasons, careful therapists working with transgender-identified teens frequently find themselves questioning, complicating, slowing, and, at times, blocking the youth's drive for rapid intervention. Such therapists do not necessarily take a child's stated wishes at face value.

52. In addition, careful therapists look for and welcome opportunities for the genuine psychological resolution of their client's gender dysphoria without resorting to medical or surgical intervention, if only to spare them the substantial burden of risks and side effects.[12]

53. Careful therapists maintain a stance of respect, acceptance, and support for their patients, even when exploring and questioning certain aspects of their presentations. They affirm the sincerity and meaningfulness of their patient's experience of gender identification, without necessarily encouraging immediate interventions. In addition, they actively encourage parental support and acceptance of the child, with

[12] Roberto D'Angelo et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Archives of Sexual Behavior 7, 12 (2021), https://perma.cc/Z5LB-TAF7.

an appreciation that parental rejection may have a significant deleterious impact on the child's mental health.[13]

C. Gender Affirming Approach

Overview of Gender Affirming Care Model

54. In the last several years, there has been a significant shift in the dominant approach for assessing and managing psychological and medical treatment for transgender youths. Most professional medical organizations in the United States now promote the model of gender affirming care (GAC) in place of the more cautious watchful waiting approach.

55. In the gender affirming care model, it is asserted that children and teenagers have a clear and consistent understanding of their subjective gender, and that a child's wish for social, medical, and surgical interventions should be accorded primacy. The American Academy of Pediatrics (AAP) published a highly influential policy statement in 2018, which states: "Accordingly, research substantiates that children who are prepubertal and assert an identity of TGD [transgender and gender diverse] know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level of social acceptance."[14] The process of gender affirmation may include social transition (such as adopting different hairstyles, clothing, and name and using a different restroom), legal transition (such as changing name and gender on birth certificate), and medical transition. Medical transition may include puberty blockers, cross-sex hormones, and surgeries. The AAP position statement asserts that this "process of reflection,

---

[13] Caitlin Ryan et al., *Family-Based Psychosocial Care for Transgender and Gender-Diverse Children and Youth*, 32 Child & Adolescent Psychiatric Clinics N. Am. 775, 775-76 (2023), https://perma.cc/8V8S-5UL3.

[14] Jason Rafferty et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics, 4 (Oct. 2018), https://perma.cc/S7U2-Z8K4.

acceptance, and, for some, intervention is known as 'gender affirmation.' It was formerly referred to as 'transitioning,' but many view the process as an affirmation and acceptance of who they have always been rather than a transition from [one] gender identity to another."[15]

56. The AAP position statement explicitly rejected the watchful waiting approach as "outdated" and endorsed gender affirmation as the only acceptable model to treat transgender and gender diverse children.[16] It also recommended the involvement of a "specialized gender-affirmative therapist" when possible.[17]

57. The Human Rights Campaign and the American Academy of Pediatrics authored a document for families and children that criticized watchful waiting (which they referred to as "delayed transition") and lauded gender affirming care as the optimal approach.[18] They noted, "Clinicians increasingly embrace a 'gender-affirming' approach to children who are gender-expansive or transgender. This approach means focusing on what the child says about their own gender identity and expression, and allowing them to determine which forms of gender expression feel comfortable and authentic."[19]

58. The World Professional Association for Transgender Health (WPATH) Standards of Care 8th edition (SOC-8) recommend that psychotherapy for gender-diverse

---

15 *Id.* at 5-6.

16 *Id.* at 4.

17 *Ibid.*

18 Gabe Murchison et al., *Supporting & Caring for Transgender Children* at 12-16, The Human Rights Campaign & The American Academy of Pediatrics (2016), https://perma.cc/N5HW-KYJ6.

19 *Id.* at 12.

youths be optional and at the discretion of the family and health care professionals, as gender diversity is not a mental disorder.[20]

59. The 2020 American Psychiatric Association Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth lays out a limited and largely supportive role for the therapist in helping to "navigate the gender affirmation process" while waiting to see "[i]f the developmental trajectory affirms the trans identity[.]"[21]

60. The affirmative approach asserts that mental health conditions will improve as a result of gender affirming care, utilizing the "minority stress model," whereas the cautious approach believes that serious mental health conditions, in many cases, should be addressed prior to making decisions around hormonal or surgical interventions with irrevocable results.

61. The model of gender affirming care, as described in the American Academy of Pediatrics and American Psychiatric Association position statements, as well as the WPATH Standards of Care 8, establishes a role for therapists that is substantially different and much more limited in certain ways from what had been traditionally understood.

62. While the model highlights the role that therapy can play in supporting, accepting, and affirming a transgender or gender-diverse individual, it makes no mention of the therapist's role in questioning or clarifying the individual's stated intentions or in disentangling the manifold influences on a youth's position. In this model, an individual's expressed wishes are simply presumed to be authentic, and the

---

[20] E. Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1, S175-76 (2022), https://perma.cc/5UE8-N7H3.

[21] *Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth* at 1, American Psychiatric Association (2020), https://perma.cc/96GS-GBKA.

therapist's role is to encourage and support them on their "gender journey." Although each of these documents expresses manifest support for shared decision making, it simultaneously establishes the gender affirming therapist as a facilitator of the transition process and makes no mention of the importance of therapeutic neutrality.

63. It is notable that none of these guidelines or standards provide any guidance regarding helping children or adolescents who desist from a transgender identification, or who decide to stop gender transition interventions.

64. Gender affirming therapy, therefore, represents more than the psychological process of acceptance and support. It is an approach in which the therapist actively supports and facilitates the youth's desire for social, medical, and eventual surgical intervention.

Interventions in Gender Affirming Care Model

65. The first stage of intervention in the gender affirming care model is known as social transition.

66. Transgender identified youths, both children and adolescents, often engage in some forms of social transition as the initial steps of intervention. They seek in doing so to present in public in a manner more congruent with the typical presentation of their expressed gender. This may involve a change of names or pronouns, as well as of dress, hairstyle, or mannerisms. It may also involve the use of techniques such as breast binding or genital tucking to minimize the outward appearance of breasts or male genitalia. Social transition is often promoted as having no inherent risks.

67. Research on the mental health benefits of social transition in children has been mixed.

68. One recent article reported that, of a group of children who were socially transitioned at the average age of 6 or 7, 94% of them continued to identify as transgender five years later, and almost half of them had already initiated medical

interventions.[22] The authors further opined that the remainder of the transgender children would likely proceed to medical intervention over time. These findings stand in contrast with earlier research indicating that transgender identified young children who are not socially transitioned experience very high rates of desistence over time (indicating a reversion to a cis-gender orientation), and raise questions as to whether social transition reinforces and solidifies what might have been a transient transgender identification.[23]

69. Recent large-scale reviews have found no evidence of positive health benefits as a result of social transitioning. One recent large study comparing gender dysphoric children who had socially transitioned to gender dysphoric children who had not, and utilizing ratings from trained mental health professionals rather than parental self-report, found no benefits.[24]

70. The Cass Review was a lengthy, comprehensive review of evidence regarding the provision of gender identity services to young people, commissioned by the English National Health Service. The final report was released in the spring of 2024.[25] In regard to social transition the Cass Review concluded that there is "no clear evidence that social transition in childhood has any positive or negative mental health outcomes, and relatively weak evidence for any effect in adolescence."[26]

---

[22] Kristina R. Olson et al., *Gender Identity 5 Years After Social Transition*, 150 Pediatrics, 3-4 at Tables 2, 3 (Aug. 2022), https://perma.cc/2GMD-MYAL.

[23] Cohen-Kettenis et al., *supra* note 4, at 1895.

[24] James S. Morandini et al., *Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria?*, 52 Archives of Sexual Behav. 1045, 1052-53 (2023), https://perma.cc/E92N-KT5C.

[25] *The Cass Review*, Independent Review of Gender Identity Services for Children and Young People (Apr. 2024), https://perma.cc/J5GN-ELUY ("Cass Review").

[26] *Id.* at 31.

71. Following social transition, the next intervention in the gender affirming care model is taking puberty blockers—gonadotropin-releasing hormone analogues, such as leuprolide and histrelin, which suppress pubertal development.

72. Although puberty blockers have been promoted as providing a child with time to consider, research indicates that the vast majority of children started on puberty blockers continue on to taking cross sex hormones.[27] Similar to the questions regarding social transition, this may reflect an extraordinarily effective selection criteria for starting on the treatment, but may also be an indication that beginning puberty blockers solidifies the child's transgender identification and places them on a steady path toward full transition when, without intervention, the child's transgender identification would likely have been transient.

73. Although puberty blockers are frequently promoted as being "fully reversible," there is no good evidence to support this supposition. It is simply not known to what extent the onset of puberty reflects a window of developmental opportunity which then closes over time.

74. The most well studied medical side effect of puberty blockers is that of decreased bone density, with the potential for the development of the disease of osteoporosis.

75. The impact of blocking puberty on a child's emotional and cognitive development is not known, although there have been reports of a drop in IQ scores in small samples of children.[28]

---

[27] Tessa Brik et al., *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 Archives of Sexual Behav. 2611, 2615-2617 (2020), https://perma.cc/VJ9B-F97M.

[28] Sallie Baxendale, *The impact of suppressing puberty on neuropsychological function: A review*, 113 Acta Paediatrica 1156, 1164-1165 (2024), https://perma.cc/5467-GJVG.

76. Blocking puberty delays the development of sexual functioning in a teenager; the physical and psychological impact of such a delay has not been well studied.[29]

77. The social and emotional impact of delaying puberty, leaving a child developmentally behind same-age peers, remains unknown.

78. Overall, the profound and pervasive changes that a child undergoes through the process of puberty are presumed to be foundational for healthy adolescent development, and there is a paucity of research as to the impact of blocking puberty in this population.

79. Following puberty blockers, the next step in a gender transition consists of masculinizing and feminizing hormones.

80. Frequently, masculinizing hormones (testosterone) are used in adolescent transgender-identified females, and feminizing hormones (estrogen plus androgen inhibitor) in adolescent transgender-identified males, in order to induce physical changes consistent with the person's gender identification.

81. In regard to hormonal treatment, the Cass Review noted: "The University of York also carried out a systematic review of outcomes of masculinising/feminising hormones. Overall, the authors concluded that 'There is a lack of high-quality research assessing the outcomes of hormone interventions in adolescents with gender dysphoria/incongruence, and few studies that undertake long-term follow-up. No conclusions can be drawn about the effect on gender dysphoria, body satisfaction, psychosocial health, cognitive development, or fertility. Uncertainty remains about the outcomes for height/growth, cardiometabolic and bone health.'"[30] As a result, the

---

[29] Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, 49 J. Sex & Marital Therapy 348, 360-362 (2023), https://perma.cc/C42Z-FE3P; Cass Review, *supra* note 25, at 176-79.

[30] Cass Review, *supra* note 25, at 33.

Report recommended "an extremely cautious clinical approach and a strong clinical rationale for providing hormones before the age of 18."[31]

82. Other systematic reviews of the research literature regarding the use of hormone treatment for gender dysphoric youths have reached similar conclusions regarding the paucity of reliable data.[32]

83. After cross-sex hormones, the next stage for a gender transition is surgery.

84. Aside from double mastectomies, surgery is not frequently performed on transgender-identified minors in the United States. Nevertheless, a recent article noted an almost 400% rise in "gender-affirming" chest surgeries in minors between 2016 and 2019, with an age range of 12 to 17 and a median age of 16.[33] Additional research indicated that between 2016 and 2020 in the United States, among youths aged 12 to 18 (including, therefore, many 18-year-olds), there were 3,215 breast surgeries and 405 genital surgeries.[34] This research did not include data from 2021 to the present.

85. Transgender-identified adult females may proceed to the surgical creation of a "neo-penis" composed of skin flaps taken from elsewhere in the body.

86. Transgender-identified adult males may have surgery to enhance breasts. They may also proceed to have their male genitalia surgically removed, followed by

---

[31] *Id*. at 34-35.

[32] Jo Taylor et al., *Masculinising and feminizing hormone interventions for adolescents experiencing gender dysphoria or incongruence: a systematic review*, Archives of Disease in Childhood at 7 (Apr. 9, 2024), https://perma.cc/SCB7-HWAP; Jonas F. Ludvigsson, *A systematic review of hormone treatment for children with gender dysphoria and recommendations for research*, 112 Acta Paediatrica 2279, 2290 (2023), https://perma.cc/EJF9-X9QL.

[33] Rishub Karan Das et al., *Gender-Affirming Chest Reconstruction Among Transgender and Gender-Diverse Adolescents in the US from 2016 to 2019*, 177 JAMA Pediatrics 89, 89 (2023), https://perma.cc/W4SA-73UV.

[34] Jason D. Wright et al., *National Estimates of Gender-Affirming Surgery in the US*, JAMA Network Open, at 4, Table 1 (Aug. 23, 2023), https://perma.cc/P9AW-YMTB.

the creation of a "neo-vagina." This neo-vagina needs to be manually dilated on a regular basis to prevent scarring and closure.

87. Some individuals choose to have both a penis and a vagina (phallus-preserving vaginoplasty or vagina-preserving phalloplasty), while some seek to have the complete removal of all external genitalia of either sex (genital nullification).

88. Some individuals may also have facial feminization surgeries, facial masculinization surgeries, or other procedures. Some surgeons advertise a curated personal surgical plan to meet the individual client's goals and expectations.

D. Criticism of the Gender Affirming Approach

Evidentiary Critiques

89. The gender affirming care model for transgender-identified youths is based on the assumptions that children and teenagers have a clear and consistent understanding of their subjective gender, and that a child's wish for social, medical, and surgical interventions should be accorded primacy. But those assumptions, and the implications for the GAC model, are being increasingly questioned and criticized.

90. The American Academy of Pediatrics position statement on transgender youth has been criticized by many, including Dr. James Cantor, a prominent clinical psychologist and sexologist, who stated, "AAP is advocating for something far in excess of mainstream practice and medical consensus. In the presence of compelling evidence, that is just what is called for. The problems with [the AAP statement], however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systemic exclusion and misrepresentation of entire literatures. Not only did AAP fail to provide

compelling evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are *despite* the existing evidence."[35]

91. The American Academy of Pediatrics has not responded to critiques such as Cantor's or the Cass Review but has recently initiated a systematic review of the relevant evidence, the results of which are pending.

92. These critiques are important because the gender affirming care model is based on the assumption that helping a child transition will lead to better health outcomes. Often, gender-affirming medical professionals claim that gender affirming care prevents suicide among transgender-identifying individuals. But studies about suicidality are either inconclusive or suffer from significant methodological flaws. For example, a study published in the Journal of the Endocrine Society, which supports gender transitions for youths, found that it "could not draw any conclusions about death by suicide."[36] Similarly, the Cass Review noted: "It has been suggested that hormone treatment reduces the elevated risk of death by suicide in this population, but the evidence found did not support this conclusion."[37]

93. In the 1990s, clinicians in the Netherlands and other sites began to publish an influential approach to transgender children that became known as the Dutch Protocol.[38] In this approach, children (primarily boys) who had been experiencing transgender identification for many years, who suffered an increase in gender dysphoria with the onset of puberty, and who had no other mental health conditions were

---

[35] James M. Cantor, *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. Sex & Marital Therapy 307, 312 (2019), https://perma.cc/LN72-LEJ7 (emphasis in original).

[36] Kellan E. Baker et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5 J. Endocrine Soc'y, at 1 (Apr. 2021), https://perma.cc/YHU2-GW72.

[37] Cass Review, *supra* note 25, at 33.

[38] Biggs, *The Dutch Protocol*, *supra* note 29, at 348.

given puberty blockers around the age of 12 and then typically provided with cross-sex hormones by around the age of 16 years.[39]

94. There is some limited research supporting the efficacy of the Dutch Protocol in the small number of youths for whom it was employed, with generally favorable degrees of satisfaction and adjustment.[40] Some studies, however, have found that the Dutch Protocol had a high risk of bias given its limited sample, its conflation of medical interventions with psychotherapy, and inconsistent measurements across time.[41]

95. In addition, the field of transgender adolescent medicine and the population of transgender-identifying youths has changed dramatically since the advent of the Dutch Protocol.

96. The number of children and adolescents identifying as transgender and presenting for care to transgender clinics has increased by orders of magnitude over the past 25 years. A recent survey noted that the number of youths receiving puberty blockers or hormone treatment in the US had more than doubled in just the four years between 2017 and 2021, and the number of child-serving transgender clinics in this country has gone from zero prior to 2007 to more than 100 at present.[42] Similarly, a recent German study of nationwide insurance data from 2013 to 2022 found an eight-fold increase in the incidence of gender identity disorders over a 10-year time period.[43] A recent analysis of US adults identifying as transgender between 2014 and 2022

---

39 *Id*. at 351.

40 *Id*. at 354-55.

41 E. Abbruzzese et al., *The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies —and research that has followed*, 49 J. Sex & Marital Therapy 673, 673 (2023), https://perma.cc/CKV7-TTLC (noting "methodological biases"); Cass Review, *supra* note 25, at 68 (noting limits).

42 Chad Terhune, et al., *As more transgender children seek medical care, families confront many unknowns*, Reuters (Oct. 6, 2022), https://perma.cc/D6KY-W9XA.

43 Bachmann, *supra* note 2, at 370.

found a fivefold increase in persons aged 18-24, a fourfold increase in persons aged 25-34, and no changes in adults older than 34.[44] The increases were entirely driven by females identifying as trans or non-binary.[45]

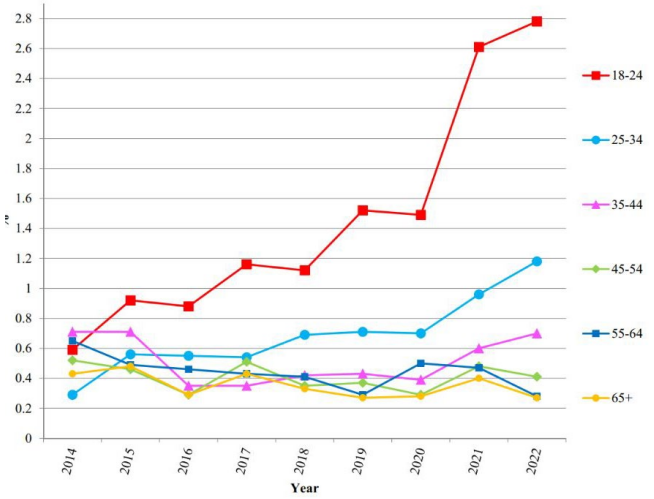

Figure 1: "Percent of US adults self-identifying as transgender, by age group, 2014–2022."[46]

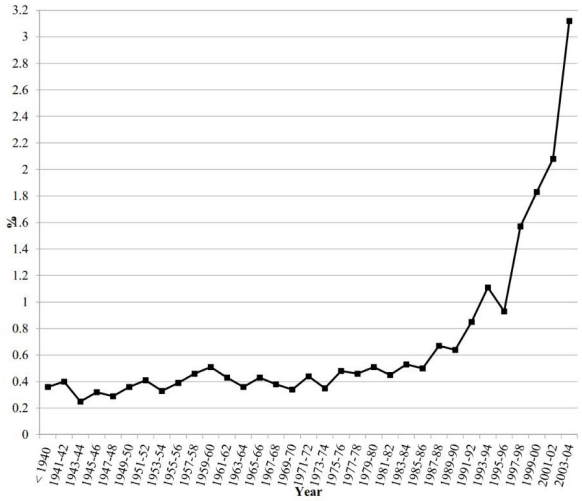

Figure 2: "Percent of US adults self-identifying as transgender, by birth year (2014–2022 data combined)."[47]

97. The reasons for the explosive growth in transgender-identified children and adolescents are not understood. Some assert that transgender children have existed throughout history and were simply unable to reveal their condition due to social disapprobation. Others note that in over a century of the scientific endeavor of studying child development there had been no reports of children expressing a transgender identification until the very recent time. Some have raised concerns about the possible role of social media, peer influence, and social contagion. Dr. Lisa

---

[44] Jean M. Twenge et al., *Increases in Self-identifying as Transgender Among US Adults, 2014–2022*, Sexual Rsch. & Soc. Pol'y, at 3 (July 13, 2024), https://perma.cc/YX3T-9HPJ.

[45] *Id.* at 3-5.

[46] *Id.* at 4.

[47] *Ibid.*

Littman, for example, described cohorts of adolescent females concurrently adopting a transgender identity in what she deemed "rapid-onset gender dysphoria."[48]

98. In addition to the increase in numbers, there has been a dramatic deterioration in the mental health status of children and adolescents presenting as transgender, such that the majority of such youths now meet the criteria for a psychiatric diagnosis.[49] A large survey of transgender-identified adults report a doubling of rates of depression and frequent mental distress in just the eight years from 2014 to 2022.[50]

99. A large number of transgender children have been diagnosed with autism spectrum disorder or present with autistic traits. Remarkably, 35% of youths referred to the National Gender Identity Development Service in England were noted to manifest moderate to severe autistic traits,[51] and a recent survey concluded that autism was found amongst gender incongruent and dysphoric individuals at eleven times the population base rate.[52] The reasons for the substantial overlap between autism and gender incongruence are not understood.

---

48 Littman, *supra* note 11, at 1.

49 Wittlin et al., *supra* note 2, at 210-12.

50 Michael Liu et al., *Health Status and Mental Health of Transgender and Gender-Diverse Adults*, JAMA Internal Med., E2 (2024), https://perma.cc/GG9G-DA3D.

51 Gary Butler et al., *Assessment of support of children and adolescents with gender dysphoria*, 103 BMJ 631, 632 (2018), https://perma.cc/5CS9-MKLS.

52 Aimilia Kallistsounaki & David M. Williams, *Autism Spectrum Disorder and Gender Dysphoria/Incongruence. A systematic Literature Review and Meta-Analysis*, 53 J. Autism & Developmental Disorders 3103, 3111 (2023), https://perma.cc/5FMH-VWNC.

100. The sex ratios of children presenting as transgender have also shifted in recent years; historically the majority of presenting youths were male, whereas now the clear majority are females.[53]

101. For all of these reasons, it is not clear that the results from the Dutch Protocol, limited though the data may be, are applicable to what appears to be a very different population of youths now presenting for transgender care.

102. Surveying the current evidence, the Cass Review concluded: "This is an area of remarkably weak evidence, and yet results of studies are exaggerated or misrepresented by people on all sides of the debate to support their viewpoint. The reality is that we have no good evidence on the long-term outcomes of interventions to manage gender-related distress."[54]

103. At the same time, there are substantiated risks and harms in medical transitions. As the Endocrine Society acknowledges, the "primary risks of pubertal suppression" to treat gender dysphoria are "adverse effects on bone mineralization," "compromised fertility if the person subsequently is treated with sex hormones," and "unknown effects on brain development."[55] For biological girls receiving testosterone, these is an increased risk of erythrocytosis, myocardial infarction, liver dysfunction, coronary artery disease, cerebrovascular disease, hypertension, and breast and

---

[53] See Madison Aitken et al., *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, 12 J. Sexual Med. 756, 760 (2015), https://perma.cc/52YF-HFJ9; *see also* Nastasja M. de Graaf et al., *Evidence for a Change in the Sex Ratio of Children Referred for Gender Dysphoria: Date From the Gender Identity Development Service in London (2000–2017)*, 15 J. Sexual Med. 1381, 1382 (2018), https://perma.cc/9RGW-REJG (noting "a significant reduction in the percentage of referred birth-assigned boys" referred to specialized gender identity clinics).

[54] Cass Review, *supra* note 25, at 13.

[55] Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869, 3882 (2017), https://perma.cc/2JPW-V26Z.

uterine cancer.[56] For biological boys receiving estrogen, this can cause sexual dysfunction and increase the risk of macroprolactinoma, coronary artery disease, cerebrovascular disease, cholelithiasis, and hypertriglyceridemia.[57]

104. Unfortunately, children and teenagers are often not mature enough to understand the risks involved in these interventions, especially as they relate to sexual functioning. But under the gender-affirming model of care, their assertions of gender identity are deemed conclusive, which means that pre-pubertal children and teenagers are effectively waiving their future right to sexual function and reproduction with, at best, limited comprehension and consent.

105. This is an important issue because, as explained above, in up to 80-95% of cases, pediatric gender dysphoria will naturally resolve (desist) by adulthood without interventions or transitioning.[58]

106. This has also led to the phenomenon of "detransitioners," or those who no longer identify as transgender and have stopped their medical interventions and sought to reverse their gender transitions.

107. In light of these uncertain benefits and concrete harms, several European countries that had previously utilized the gender affirming care model with transgender-identified youths have recently conducted systematic evidence reviews and, as a result, have chosen to adopt a more traditional and cautious approach.

---

[56] *Id.* at 3886, 3891; Michael K. Laidlaw et al., *Letter to the Editor From Laidlaw et al: "Erythrocytosis in a Large Cohort of Transgender Men Using Testosterone: A Long-term Follow-up Study on Prevalence, Determinants, and Exposure Years"*, 106 J. Clinical Endocrinology & Metabolism e5275, e5275 (June 9, 2021), https://perma.cc/6GDZ-J77V ("Studies of transgender males taking testosterone have shown up to a nearly 5-fold increased risk of myocardial infarction relative to females not receiving testosterone.").

[57] Hembree et al., *supra* note 55, at 3886.

[58] Cohen-Kettenis et al., *supra* note 4, at 1893; Kaltiala-Heino et al., *supra* note 4, at 32-33.

108. The United Kingdom previously ran one of the largest pediatric gender clinics in the world at the Tavistock and Portman NHS Foundation Trust. The Cass Review studied how the British government was running the Tavistock Clinic and whether there was scientific evidence supporting medical transitions for minors.[59]

109. The Cass Review questioned the quality of currently available guidelines and singled out the influential 2022 WPATH guidelines for lacking "rigour of development."[60]

110. The Cass Review concluded: "The systematic review of psychosocial interventions found that the low quality of the studies, the poor reporting of the intervention details, and the wide variation in the types of interventions investigated, meant it was not possible to determine how effective different interventions were for children and young people experiencing gender distress."[61]

111. It recommended that "Standard evidence based psychological and psychopharmacological treatment approaches should be used to support the management of the associated distress and cooccurring conditions."[62]

112. In regard to puberty blockers, the review noted, "The Review's letter to NHS England (July 2023) advised that because puberty blockers only have clearly defined benefits in quite narrow circumstances, and because of the potential risks to neurocognitive development, psychosexual development and longer-term bone health, they should only be offered under a research protocol."[63]

---

59 Cass Review, *supra* note 25, at 78-80.

60 *Id*. at 128-132.

61 *Id*. at 30.

62 *Id*. at 31.

63 *Id*. at 32.

113. The English National Health Services is making major changes in their provision of services for transgender-identified youths as a result of this report.[64]

114. The United Kingdom has since closed the Tavistock Clinic and has issued an emergency order banning the private use of puberty-suppressing hormones for new patients under 18.[65]

115. Finland, Sweden, Denmark, and Norway have each conducted systematic reviews of the evidence regarding the treatment of transgender-identified youths and have found the research insufficient to support medical or surgical interventions in this population, except under very limited conditions.

116. Finland engaged in a systematic evidence review and found the evidence supporting pediatric gender transitions was weak and inconclusive.[66] It recommended that "[t]he first-line intervention for gender variance during childhood and adolescent years is psychosocial support and, as necessary, gender-explorative therapy and treatment for comorbid psychiatric disorders."[67]

117. Sweden published national guidelines finding that for more children, the risks of gender affirming care likely outweighed any benefits.[68]

---

64 Azeen Ghorayshi, *Youth Gender Medications Limited in England, Part of Big Shift in Europe*, N.Y. Times (Apr. 9, 2024), https://perma.cc/VSF2-BSWT.

65 *New restrictions on puberty blockers*, United Kingdom Department of Health and Social Care (May 29, 2024), https://perma.cc/8LLN-DY29.

66 *Suositus: Transsukupuolisuudesta johtuvan dysforian lääketieteelliset hoitomenetelmät* [*Recommendation: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors*], Palveluvalikoimaneuvoston [The Council for Choices in Health Care in Finland (COHERE Finland)], at 6-8 (June 11, 2020) (Fin.), https://perma.cc/CV8A-FLRV, *unofficial English translation*, https://perma.cc/AA6W-P5HJ.

67 *Id.* at 5.

68 Gunilla Sonnebring, *Systematic review on outcomes of hormonal treatment in youths with gender dysphoria*, Karolinska Institutet (Apr. 20, 2023) (Swed.), https://perma.cc/W444-9VZY.

118. In Denmark, guidelines limit hormone treatments to adolescents who have experienced persistent dysphoria that is not of "short duration."[69] Unstable psychosocial conditions can also bar an adolescent from receiving medical transition.[70] This has led to a drastic decrease in the provision of hormone treatments.

119. A Norwegian government investigation found that there is insufficient evidence for the use of puberty blockers and cross-sex hormones in young people.[71]

120. Countries outside of Europe have also backed away from the gender affirming care model. In 2023, the Royal Australian and New Zealand College of Psychiatrists withdrew support for the gender affirming standards of care in Australia, and instead issued a statement highlighting the limited evidence base regarding the benefits and potential harms of psychosocial and medical intervention for transgender youth.[72]

121. Concerns about the limited role of psychotherapy in the current iteration of gender affirming care were raised by two leaders in the field and former WPATH members in a widely read 2021 article in the Washington Post entitled "The Mental Health Establishment is Failing Trans Kids." Drs. Laura Edwards-Leeper and Erica Anderson wrote, "Providers and their behavior haven't been closely studied, but we find evidence every single day, from our peers across the country and concerned parents who reach out, that the field has moved from a more nuanced, individualized

---

[69] Mette Vinther Hansen et al., *Sundhedsfaglige tilbud til børn og unge med Kønsubehag* [*Health services for children and young people with gender dysphoria*], 185 Ugeskr Læger [Wkly. Mag. for Drs.], (2023) (Den.), https://perma.cc/PWL2-FR38, *translated via Google Translate*, https://perma.cc/CG8T-K3PK.

[70] *Id.* at 3.

[71] Jennifer Block, *Norway's guidance on paediatric gender treatment is unsafe, says review*, 380 BMJ 697 (2023), https://perma.cc/9XJF-MRY4.

[72] *Position Statement: The role of psychiatrists in working with Trans and Gender Diverse people*, The Royal Australian and New Zealand College of Psychiatrists (Dec. 2023), https://perma.cc/7QES-JUC8.

and developmentally appropriate assessment process to one where every problem looks like a medical one that can be solved quickly with medication or, ultimately, surgery. As a result, we may be harming some of the young people we strive to support – people who may not be prepared for the gender transitions they are being rushed into."[73]

122. Dr. Edwards Leeper was the past Chair of the Child and Adolescent Committee for WPATH and was involved in the WPATH Standards of Care (SOC) 8 revision. Dr. Anderson is a former board member of WPATH.[74]

123. Internal WPATH documents and correspondence, recently unsealed as part of a federal court proceeding in Alabama, have cast serious doubt on the process used to develop WPATH's standards of care. These documents reveal that WPATH "leaders interfered with the production of systematic reviews that it had commissioned from the Johns Hopkins University Evidence-Based Practice Centre (EPC) in 2018."[75] They also show that "the SOC-8 development process was extensively influenced by factors other than medical science, including political pressure, litigation and legislative advocacy strategy, and financial self-interest of WPATH members."[76]

Historical Context

124. The history of the modern era of psychiatry has been characterized, in part, by real and sustained advances in treatment, particularly in the domains of patient rights, effective psychotherapies, and psychiatric medications.

---

[73] Laura Edwards-Leeper & Erica Anderson, *The mental health establishment is failing trans kids*, The Washington Post (Nov. 24, 2021), https://perma.cc/82UE-LXPQ.

[74] *Id.*

[75] *Research into trans medicine has been manipulated*, The Economist (June 27, 2024), https://perma.cc/AD6E-HMQQ.

[76] *Ex. 24 to United States' Br. in Supp. of Mot. to Exclude* at vi, *Boe v. Marshall*, No. 2:22-cv-184 (M.D. Ala. June 24, 2024), ECF No. 591-24, https://perma.cc/W6RJ-LDE2 (Appendix A. to Supplemental Expert Report of James Cantor, Ph.D.).

125. At the same time, there have been numerous instances of psychiatric fads and frenzies, both remote and recent, in which a dramatic widespread enthusiasm for a particular intervention or concept, often endorsed by leaders in the field, proves over time to be illusory, over-promoted, or dangerous. These have included "surgical bacteriology" (removing organs to cure mental illness), insulin shock, compulsory sterilization, lobotomy and other psychosurgeries, early electroconvulsive therapy, the concept of the "schizophrenogenic mother," the misuse of aversive conditioning, recovered memories and satanic ritual abuse, the over-diagnosis of multiple personality disorder and juvenile bipolar disorder, and arguably the overuse of certain psychiatric medications.

126. The field of psychiatry, it would seem, may be less mature in some respects than other medical specialties—lacking biological markers for illness, lacking effective animal models, and lacking a genuine understanding of the basis of disease—and so may be more susceptible to such paroxysms of enthusiasm.

127. An appreciation of the sometimes-checkered history of psychiatry does not necessarily lead to therapeutic nihilism but rather to two related conclusions: First, that novel interventions need to be carefully established on a foundation of research and experience, and second, that the ancient dictum "First do no harm" remains as true for clinicians today as it did thousands of years ago.

128. The current approach of gender affirming care for transgender-identified individuals represents a recent, dramatic departure from how the field of psychiatry has historically treated individuals who present with distress due to other disordered perceptions of or relationships with their bodies—such as body dysmorphic disorder, body integrity identity disorder, anorexia nervosa, muscle dysmorphia, or eunuch identification.

129. In those other cases, psychiatry has typically attempted to help the individual come to terms with their body through psychological means rather than attempting to alter the body to bring it into terms with their psyche.

130. Whether and in what ways gender dysphoria may be related to these other psychiatric diagnostic conditions remains unclear, and there are important distinctions that can be made between them. What is clear, however is that gender affirming care represents a departure from the long tradition of psychiatry seeking psychological relief rather than medical and surgical modification for distress regarding one's healthy body.

III. Conversion Therapy

Conversion Therapy Historically

131. "Conversion therapy" is not a term of art in the mental health field and has no clearly defined meaning.

132. It does, however, have specific, historical associations. Conversion therapy—also known as reparative therapy or "sexual orientation change efforts" (SOCE)—was a method of therapy that sometimes involved the use of coercion, shaming, or aversive conditioning in efforts to modify same sex attraction in certain individuals. Conversion therapy was openly used at times during the last half of the 20th century.

133. Since that time, conversion therapy has been broadly repudiated, even by its former practitioners, such that there is at present a near-universal consensus amongst mental health practitioners that such methods are both futile and often psychologically harmful.

134. The authoritative 2009 APA (American Psychological Association) Task Force on Appropriate Therapeutic Responses to Sexual Orientation reached the following conclusions:[77]

a. The task force noted, "We have serious concerns that the coercive or involuntary treatment of children or adolescents has the potential to be harmful and may potentially violate current clinical and practice guidelines, standards for ethical practice, and human rights.

b. The task force concluded that treatments based on the assumption that homosexuality is a mental disorder should be avoided due to the possible harm to patients through the reinforcement of stereotypes and increase in internalized stigma.

c. The task force recommended "affirmative therapeutic intervention" [in the more customary meaning of the word "affirmative"] that included acceptance and support, reduction of stigma and isolation, identity exploration and development, and family reconciliation techniques.

135. At the same time, the Guidelines also noted that participants had different views on SOCE. "Recent research indicates that former participants in SOCE report diverse evaluations of their experiences. Some individuals perceive that they have benefited from SOCE, while other individuals perceive that they have been harmed by SOCE."[78]

136. Per the Guidelines, "[b]oth the early and recent research provide little clarity on the associations between claims to modify sexual orientation from same-sex to other-sex and subsequent improvements or harm to mental health."[79]

---

[77] *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation* at 81-88, American Psychological Association (Aug. 2009), https://perma.cc/6FWH-XJ5D.

[78] *Id*. at 85.

[79] *Ibid*.

Sexual Orientation Identity

137. The 2009 APA guidelines also drew a distinction between sexual orientation and sexual orientation *identity*.[80] In contrast to what used to be called conversion or reparative therapy, some therapists at present work with clients in an effort to modify their behaviors rather than their sexual orientation, emphasizing self-determination, acceptance, and support.

138. There is no clear evidence that such therapy (in contrast to the historical reparative therapy) is harmful, and it appears to fall within the guidelines suggested by the APA task force.

139. Indeed, the task force highlighted the distinction between sexual orientation (which is unlikely to change through therapy) and sexual orientation identity (including self-labeling, values, and behavior), which some individuals were able to modify.[81]

140. The APA Task force notes: "Self-determination is the process by which a person controls or determines the course of her or his own life … [Licensed mental health providers] maximize self-determination by (a) providing effective psychotherapy that explores the client's assumptions and goals, without preconditions on the outcome; (b) providing resources to manage and reduce distress; and (c) permitting the client to decide the ultimate goal of how to self-identify and live out her or his sexual orientation."[82]

141. It also explains that counseling to modify sexual orientation *identity* could be helpful: "Other individuals reported that SOCE was helpful—for example, it helped them live in a manner consistent with their faith. Some individuals described finding a sense of community through religious SOCE and valued having others with whom

---

[80] *Id.* at 84.

[81] *Ibid.*

[82] *Id.* at 6.

they could identify. These effects are similar to those provided by mutual support groups for a range of problems, and the positive benefits reported by participants in SOCE, such as reduction of isolation, alterations in how problems are viewed, and stress reduction, are consistent with the findings of the general mutual support group literature. The research literature indicates that the benefits of SOCE mutual support groups are not unique and can be provided within an affirmative and multiculturally competent framework, which can mitigate the harmful aspects of SOCE by addressing sexual stigma while understanding the importance of religion and social needs."[83]

Conversion Therapy Prevalence

142. There is no evidence that coercive, shaming, or aversive conditioning is commonly used by counselors or licensed mental health practitioners at the present time in efforts to modify either same-sex attraction or gender identification.

143. Survey results from a non-representative population from 2015 indicated that in the preceding 5 years only 5% of respondents endorsed the exceptionally broad question: "Did any professional (such as a psychologist, counselor, religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?"[84] The survey in question did not inquire specifically about coercive, shaming, or aversive approaches. The 2015 US Transgender Survey reported that 13% of their survey population had had a professional person try to stop

---

[83] *Id*. at 3.

[84] Jack L. Turban et al., *Psychological Attempts to Change a Person's Gender Identity From Transgender to Cisgender: Estimated Prevalence Across US States, 2015*, 109 Am. J. Pub. Health 1452, 1453 (2019), https://perma.cc/ZR7C-LWEM; Travis Salway et al., *A systematic review of the prevalence of lifetime experience with 'conversion' practices among sexual and gender minority populations*, PLOS ONE, 9 (Oct. 4, 2023), https://perma.cc/8C42-3DLH.

them from being transgender; 4% had seen a religious professional, and 9% had a non-religious professional.[85]

144. The Trevor Project, a LGBTQ+ advocacy group, recently conducted a comprehensive survey of online information in order to identify what they referred to as Conversion Therapists.[86] They reported "more than 600 practitioners who hold active professional licenses" who engage in conversion therapy,[87] or approximately 0.08% of the total such professionals in the United States.[88] Their inclusion criteria included therapists who described themselves online simply as working with "sexuality issues" and "gender identity issues."[89] There was no indication that any of these therapists utilized coercion, shaming, or aversive techniques in their practices.

145. Very little research has been conducted on the potential impact of Gender Identity Change Efforts on transgender individuals. One cross-sectional study found an association between GICE and psychological distress.[90] However, that study has been criticized on several grounds, including its reliance on retrospective reporting and its inability to discern the direction of causation.[91]

---

85 *The Report of the 2015 U.S. Transgender Survey*, National Center for Transgender Equality at 109 (Dec. 2017), https://perma.cc/L3Y4-GDMK.

86 *It's Still Happening: A Report on Practitioners of So-Called Conversion "Therapy" in the U.S.* at 10-11, The Trevor Project (2023), https://perma.cc/UVR9-9FS8.

87 *Id.* at 14 (including licensed professional counselors, marriage and family therapists, social workers, and psychologists).

88 Traci Pedersen, *How Many Mental Health Professionals Are There in the U.S.?*, PsychCentral (May 1, 2023), https://perma.cc/CB9F-JUZQ (estimating 351,000 licensed counselors, 65,300 marriage and family therapists, 113,810 social workers in mental health, 181,600 psychologists, and 25,530 psychiatrists in the U.S.); 620 ÷ 737,240 = 0.0008 or 0.08%.

89 The Trevor Project, *supra* note 86, at 10.

90 Jack Turban et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA Psychiatry 68, 68 (2020), https://perma.cc/4HYU-ZHM8.

91 D'Angelo et al., *One Size Does Not Fit All*, *supra* note 12, at 8-14.

146. The US 2015 Transgender Survey included quotes from several transgender teens who had been exposed to conversion therapy in the past. One teenager referred to physical abuse by their parents, one to being forced to take oral contraceptives against their will, and one to being kicked out of the house. In addition, the survey noted that participants who reported that a professional had tried to stop them from being transgender were more likely to have run away from home, to have experienced homelessness, and to have engaged in sex work. These findings point to a very real possibility (for which there is no research data that I am aware of) that individuals who report a history of having had professionals try to stop them from being transgender are more likely to have come from families who were unsupportive and even rejecting.

147. This is consistent with research on the crucial role of family acceptance and support in maintaining the psychological well-being of transgender-identified youth.[92] The Family Acceptance Project, for example, has demonstrated the value of working with parents and families of transgendered identified youth in a respectful and non-judgmental manner.[93] Others have noted, "Clinicians can support parents and caregivers in moving away from an all-or-nothing view of having to choose between their child and their culture and faith by staying focused on parents' underlying values, their love for their child, and their desire for their child to live a safe and healthy life."[94]

148. Advocates of gender affirming care, as well as established medical organizations that support the gender affirmative approach, have frequently attempted to conflate mainstream exploratory therapy with conversion therapy and the

---

92 Ryan et al., *supra* note 13.

93 *Id*. at 781.

94 *Id*. at 787.

discredited use of coercive, shaming, or aversive techniques.[95] They fail to acknowledge meaningful distinctions between the two, covering both with the odious mantle of disapproval that conversion therapy has justifiably earned. This grouping of distinct practices "is highly questionable."[96]

149. Recent official statements from major medical organizations as well as advocacy groups have often recognized only two therapeutic approaches to transgender identified youths: affirmative therapy and its nemesis, conversion therapy, tacitly relegating traditional therapy to the highly problematic status of being not meaningfully different from conversion therapy.

150. The use of the term 'affirmative therapy' or 'gender affirming care' contributes to this confusion. If "affirmative therapy" is defined as a therapy that actively supports a youth's request for medical or surgical intervention, then any therapy that takes a more cautious approach is, by extension, "disaffirmative" and, therefore, not meaningfully different from conversion therapy.

151. Similarly, every effective psychotherapy needs to be "affirming" at its core—recognizing a patient's strengths and resources, sharing a vision of growth and possibility, and encouraging the patient's efforts at change. The conflation of psychologically supportive therapy with active steps to medical intervention leaves little room for a therapy that is deeply respectful and attuned, yet careful and curious at the same time.

152. The American Psychiatric Association 2018 Position Statement on Conversion Therapy and LGBTQ Patients "encourages psychotherapies which affirm individuals' sexual orientations and gender identities," encourages legislation prohibiting

---

95 Robert D'Angelo, *Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy*, J. Med. Ethics, 2-3 (Nov. 18, 2023), https://perma.cc/W9SN-HSFT.

96 *Ibid.*

conversion therapy, and makes no mention of traditional psychotherapy.[97] As the "affirm[ation] [of] gender identities" in the gender affirming care model includes facilitating whichever interventions the patient requests, this statement provides no role for a more cautious therapeutic approach.[98]

IV. Conversion Therapy Bans

153. Legislative bans on conversion therapy in various states in the United States, and the discourse surrounding those bans, have often conflated the cautious, mainstream, exploratory approach to transgender-identified youths with the long-discredited, coercive, shaming, and aversive conversion therapy used in the latter half of the 20th century to try to change sexual orientation.[99] This appears to be part of an effort to promote gender affirming care as the only acceptable therapeutic approach to transgender-identified youths and to impugn any degree of therapeutic caution or concern as discredited "conversion therapy."

154. The care of transgender children and adolescents has become highly politicized and hotly debated. Dr. Cass noted in her report that, "Despite the best intentions of everyone with a stake in this complex issue, the toxicity of the debate is exceptional. … There are few other areas of healthcare where professionals are so afraid to openly discuss their views, where people are vilified on social media, and where name-calling echoes the worst bullying behavior. This must stop."[100]

155. The Cass Review noted that "[t]erms such as 'affirmative' and 'exploratory' approaches have been weaponised[.]"[101] The Report also states, "The intent of

---

[97] *Position Statement on Conversion Therapy and LGBTQ Patients* at 2, American Psychiatric Association (Dec. 2018), https://perma.cc/Z3T7-TXMC.

[98] *Ibid.*

[99] D'Angelo, *Supporting autonomy*, *supra* note 95, at 2-3.

[100] Cass Review, *supra* note 25, at 13.

[101] *Id.* at 150.

psychological intervention is not to change the person's perception of who they are but to work with them to explore their concerns and experiences and help alleviate their distress, regardless of whether they pursue a medical pathway or not. It is harmful to equate this approach to conversion therapy as it may prevent young people from getting the emotional support they deserve."[102]

156. The Cass Review noted that many primary and secondary care clinicians were fearful of working with this population due to the surrounding social debate.[103]

157. In a qualitative survey of clinicians conducting exploratory therapy for transgender-identified individuals, the great majority described working in a pervasively hostile environment, and about half identified anxiety regarding a complaint or hostile action as a primary concern.[104]

158. There have been numerous reports in the popular press over the last few years of clinicians who have publicly raised concerns around the gender affirming care model, and who then suffered professional retribution.

159. The authors of the WPATH SOC-8 Chapter on Adolescents, leaders in the field of transgender health care, were subjected to a furious response from colleagues and activists for recommending a comprehensive biopsychosocial assessment prior to the initiation of medical treatment.[105]

160. In my experience, it is very difficult for parents to find therapists for their children who take a stance other than that of "gender affirming." I am listed on a website as someone who engages in exploratory therapy with trans-identified youths,

---

[102] *Ibid.*

[103] *Id.* at 20, 22, 202.

[104] Peter Jenkins & Dwight Panozzo, *"Ethical Care in Secret": Qualitative Data from an International Survey of Exploratory Therapists Working with Gender-Questioning Client*, 50 J. Sex & Marital Therapy 557, 565-67 (2024), https://perma.cc/HK74-4727.

[105] Emily Bazelon, *The Battle Over Gender Therapy*, N.Y. Times Magazine (Mar. 17, 2023), https://perma.cc/M727-LSF7.

and my solo practice receives between 50 and 100 inquiries a year from parents of transgender children, almost all of whom express a fear that taking their child to an explicitly gender affirming therapist will establish and accelerate the process of medical intervention, and almost all of whom report on the extraordinary difficulty of finding a therapist who is willing to take an open-ended, exploratory stance.

161. A therapist who strives to enhance family acceptance of their transgender identified child may elicit and explore the family's concerns and values in a non-judgmental manner. They may conclude in certain situations that moving ahead with medical intervention at a particular point in time risks eroding the family's stance of support. That sort of therapeutic balancing act could well be seen, from the perspective of an impatient and distrustful teenager, as a clandestine effort at conversion, and as a legitimate target for a professional complaint if the therapy goes awry.

162. Similarly, teenagers often come into therapy with their own cultural and religious beliefs, distress at the discordance between different aspects of their identity, and ideas as to how best to resolve their dilemmas. Open-minded therapists express genuine respect for the authenticity of all facets of the individual, maintaining a 'therapeutic neutrality' regarding optimal outcomes. In situations where a teenager expresses a wish to explore the possibility of affirming a cis-gender identification in accord with their values and beliefs, the therapist needs to be able to support that desire without fear of retribution.

163. A careful therapist may appreciate that while there are some individuals for whom a transgender identification provides a satisfying and sustainable resolution, there are others for whom it may not be the prudent choice at that point in time. Given the challenges of distinguishing between such individuals (especially amidst the turmoil of adolescence), the irrevocable nature of the proposed interventions, the limited research base, and the substantial medical risks involved, such a therapist

may in some cases suggest psychotherapy and time as the optimal path, prior to the in initiation of irrevocable interventions.

164. At such times, the careful therapist may appear indistinguishable from someone whose sole intent is to prevent the youth from moving forward with interventions. Indeed, a therapy that coincided or contributed to a teenager shifting from a transgender identification to a cisgender identification could credibly be accused of being a form of 'conversion,' quite independent of the open-mindedness of the therapist as to the outcome.

165. As a result, a therapist who wished to effectively inoculate themselves against accusations of practicing "conversion therapy" would need to adopt a gender affirming approach, treating the young person's declarations and intentions as beyond question.

166. In a field that appears at times to be dominated by ideologues and extremists on each side, there is a pressing need for therapists and clinicians who are both open-minded and careful. Conversion therapy bans, however, threaten those clinicians who choose caution at times. In the current highly charged professional atmosphere, many reasonable therapists will decline to expose themselves to the risks of litigation and loss of license at the hands of a frustrated patient or a zealous advocate. Some will avoid working with this population altogether, while others will learn to overlook their clinical misgivings in order to avoid any appearance of being less than fully affirming.[106]

167. Conversion therapy bans have the effect of enshrining gender affirming care as the sole acceptable approach to transgender youths at a time when the elements

[106] Cass Review, *supra* note 25, at 202 ("Throughout the Review, clinicians working with this population have expressed concerns about the interpretation of potential legislation on conversion practices and its impact on the practical challenges in providing professional support to gender-questioning young people. This has left some clinical staff fearful of accepting referrals of these children and young people.").

of optimal clinical treatment are far from settled and when the mental health needs of this population are so pressing. In doing so, such bans may, in fact, be depriving this vulnerable population of sorely needed psychological treatment while at the same time exposing them to the risks of unnecessary and irrevocable interventions.

Executed this 18 day of July, 2024.

Dr. Andrew Clark

References

Abbruzzese, E. et al., *The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies —and research that has followed*, 49 J. Sex & Marital Therapy 673 (2023), https://perma.cc/CKV7-TTLC.

Aitken, Madison et al., *Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria*, 12 J. Sexual Med. 756 (2015), https://perma.cc/52YF-HFJ9.

American Psychological Association, *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People*, 70 Am. Psych. 832 (Dec. 2015), https://perma.cc/W787-NSYW.

Bachmann, Christian J. et al., *Störungen der Geschlechtsidentität bei jungen Menschen in Deutschland: Häufigkeit und Trends 2013–2022* [*Gender identity disorders among young people in Germany: prevalence and trends, 2013–2022. An analysis of nationwide routine insurance data*], 121 Deutsches Ärzteblatt [German Med. J.] 370 (May 31, 2024) (Ger.), https://perma.cc/X5X8-MG4E, *translated via Google Translate*, https://perma.cc/6LPG-XWBV, *official English translation forthcoming*, https://www.aerzteblatt.de/int/archive/article/239563.

Baker, Kellan E. et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5 J. Endocrine Soc'y (Apr. 2021), https://perma.cc/YHU2-GW72.

Baxendale, Sallie, *The impact of suppressing puberty on neuropsychological function: A review*, 113 Acta Paediatrica 1156 (2024), https://perma.cc/5467-GJVG.

Bazelon, Emily, *The Battle Over Gender Therapy*, N.Y. Times Magazine (Mar. 17, 2023), https://perma.cc/M727-LSF7.

Becerra-Culqui, Tracy A. et al., *Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers*, 141 Pediatrics (2018), https://perma.cc/U2XX-XG7S.

Biggs, Michael, *Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom*, 51 Archives of Sexual Behav. 685 (2022), https://perma.cc/77EF-YY3P.

Biggs, Michael, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, 49 J. Sex & Marital Therapy 348 (2023), https://perma.cc/C42Z-FE3P.

Block, Jennifer, *Norway's guidance on paediatric gender treatment is unsafe, says review*, 380 BMJ 697 (2023), https://perma.cc/9XJF-MRY4.

Brik, Tessa et al., *Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria*, 49 Archives of Sexual Behav. 2611 (2020), https://perma.cc/VJ9B-F97M.

Butler, Gary et al., *Assessment of support of children and adolescents with gender dysphoria*, 103 BMJ 631 (2018), https://perma.cc/5CS9-MKLS.

Cantor, James M. *Transgender and Gender Diverse Children and Adolescents: Fact-Checking of AAP Policy*, 46 J. Sex & Marital Therapy 307 (2019), https://perma.cc/LN72-LEJ7.

Cohen-Kettenis, Peggy T. et al., *The Treatment of Adolescent Transsexuals: Changing Insights*, 5 J. Sexual Med. 1892 (2008), https://perma.cc/75GQ-483Z.

Coleman, E. et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 Int'l J. Transgender Health S1 (2022), https://perma.cc/5UE8-N7H3.

D'Angelo, Robert, *Supporting autonomy in young people with gender dysphoria: psychotherapy is not conversion therapy*, J. Med. Ethics (Nov. 18, 2023), https://perma.cc/W9SN-HSFT.

D'Angelo, Roberto et al., *One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria*, 50 Archives Sexual Behav. 7 (2021), https://perma.cc/Z5LB-TAF7.

Das, Rishub Karan et al., *Gender-Affirming Chest Reconstruction Among Transgender and Gender-Diverse Adolescents in the US from 2016 to 2019*, 177 JAMA Pediatrics 89 (2023), https://perma.cc/W4SA-73UV.

De Graaf, Nastasja M. et al., *Evidence for a Change in the Sex Ratio of Children Referred for Gender Dysphoria: Date From the Gender Identity Development Service in London (2000–2017)*, 15 J. Sexual Med. 1381 (2018), https://perma.cc/9RGW-REJG.

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition: DSM-5, American Psychiatric Association (2013), https://perma.cc/2SL2-HV3D.

Edwards, Laura Edwards-Leeper & Anderson, Erica, *The mental health establishment is failing trans kids*, The Washington Post (Nov. 24, 2021), https://perma.cc/82UE-LXPQ.

Ex. 24 to United States' Br. in Supp. of Mot. to Exclude, *Boe v. Marshall*, No. 2:22-cv-184 (M.D. Ala. June 24, 2024), ECF No. 591-24, https://perma.cc/W6RJ-LDE2.

Ghorayshi, Azeen, *Youth Gender Medications Limited in England, Part of Big Shift in Europe*, N.Y. Times (Apr. 9, 2024), https://perma.cc/VSF2-BSWT.

Hansen, Mette Vinther et al., *Sundhedsfaglige tilbud til børn og unge med Kønsubehag* [*Health services for children and young people with gender dysphoria*], 185 Ugeskr Læger [Wkly. Mag. for Drs.], (2023) (Den.), https://perma.cc/PWL2-FR38, *translated via Google Translate*, https://perma.cc/CG8T-K3PK.

Hembree, Wylie C. et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline*, 102 J. Clinical Endocrinology & Metabolism 3869 (2017), https://perma.cc/2JPW-V26Z.

It's Still Happening: A Report on Practitioners of So-Called Conversion "Therapy" in the U.S., The Trevor Project (2023), https://perma.cc/UVR9-9FS8.

Jenkins, Peter & Panozzo, Dwight, *"Ethical Care in Secret": Qualitative Data from an International Survey of Exploratory Therapists Working with Gender-Questioning Client*, 50 J. Sex & Marital Therapy 557 (2024), https://perma.cc/HK74-4727.

Kallistsounaki, Aimilia & Williams, David M., *Autism Spectrum Disorder and Gender Dysphoria/Incongruence. A systematic Literature Review and Meta-Analysis*, 53 J. Autism & Developmental Disorders 3103 (2023), https://perma.cc/5FMH-VWNC.

Kaltiala-Heino, Rittakerttu et al., *Gender dysphoria in adolescence: current perspectives,* 9 Adolescent Health, Med., & Therapeutics 31 (2018), https://perma.cc/84D8-MDNR.

Laidlaw, Michael K. et al., *Letter to the Editor From Laidlaw et al: "Erythrocytosis in a Large Cohort of Transgender Men Using Testosterone: A Long-term Follow-up Study on Prevalence, Determinants, and Exposure Years"*, 106 J. Clinical Endocrinology & Metabolism e5275 (June 9, 2021), https://perma.cc/6GDZ-J77V.

Littman, Lisa, *Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria*, PLOS ONE (Aug. 16, 2018), https://perma.cc/6TNW-SVKL, *updated on different grounds*, *Correction: Parent reports of adolescents and young adults perceived to show signs of rapid onset of gender dysphoria*, PLOS ONE (Mar. 19, 2019), https://perma.cc/63E7-KWRA.

Liu, Michael et al., *Health Status and Mental Health of Transgender and Gender-Diverse Adults*, JAMA Internal Med., E2 (2024), https://perma.cc/GG9G-DA3D.

Ludvigsson, Jonas F. *A systematic review of hormone treatment for children with gender dysphoria and recommendations for research*, 112 Acta Paediatrica 2279 (2023), https://perma.cc/EJF9-X9QL.

Morandini, James S. et al., *Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria?*, 52 Archives Sexual Behav. 1045 (2023), https://perma.cc/E92N-KT5C.

Murchison, Gabe et al., *Supporting & Caring for Transgender Children*, The Human Rights Campaign & The American Academy of Pediatrics (2016), https://perma.cc/N5HW-KYJ6.

New restrictions on puberty blockers, United Kingdom Department of Health and Social Care (May 29, 2024), https://perma.cc/8LLN-DY29.

Olson, Kristina R. et al., *Gender Identity 5 Years After Social Transition*, 150 Pediatrics (Aug. 2022), https://perma.cc/2GMD-MYAL.

Pedersen, Traci, *How Many Mental Health Professionals Are There in the U.S.?*, PsychCentral (May 1, 2023), https://perma.cc/CB9F-JUZQ.

Position Statement on Conversion Therapy and LGBTQ Patients, American Psychiatric Association (Dec. 2018), https://perma.cc/Z3T7-TXMC.

Position Statement on Treatment of Transgender (Trans) and Gender Diverse Youth, American Psychiatric Association (2020), https://perma.cc/96GS-GBKA.

Position Statement: The role of psychiatrists in working with Trans and Gender Diverse people, The Royal Australian and New Zealand College of Psychiatrists (Dec. 2023), https://perma.cc/7QES-JUC8.

Rafferty, Jason et al., *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 Pediatrics (Oct. 2018), https://perma.cc/S7U2-Z8K4.

Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, American Psychological Association (Aug. 2009), https://perma.cc/6FWH-XJ5D.

Research into trans medicine has been manipulated, The Economist (June 27, 2024), https://perma.cc/AD6E-HMQQ.

Ruuska, Sami-Matti et al., *All-cause and suicide mortalities among adolescents and young adults who contacted specialised gender identity services in Finland in 1996–2019: a register study*, 27 BMJ Mental Health (Feb. 17, 2024), https://perma.cc/A5WN-47F4.

Ryan, Caitlin et al., *Family-Based Psychosocial Care for Transgender and Gender-Diverse Children and Youth*, 32 Child & Adolescent Psychiatric Clinics N. Am. 775 (2023), https://perma.cc/8V8S-5UL3.

Salway, Travis et al., *A systematic review of the prevalence of lifetime experience with 'conversion' practices among sexual and gender minority populations*, PLOS ONE (Oct. 4, 2023), https://perma.cc/8C42-3DLH.

Singh, Devita et al., *A Follow-Up Study of Boys With Gender Identity Disorder*, 21 Frontiers in Psychiatry (Mar. 2021), https://perma.cc/5JUL-AU6F.

Sonnebring, Gunilla, *Systematic review on outcomes of hormonal treatment in youths with gender dysphoria*, Karolinska Institutet (Apr. 20, 2023) (Swed.), https://perma.cc/W444-9VZY.

Suositus: Transsukupuolisuudesta johtuvan dysforian lääketieteelliset hoitomenetelmät [*Recommendation: Medical Treatment Methods for Dysphoria Related to Gender Variance in Minors*], Palveluvalikoimaneuvoston [The

Council for Choices in Health Care in Finland (COHERE Finland)] (June 11, 2020) (Fin.), https://perma.cc/CV8A-FLRV, *unofficial English translation*, https://perma.cc/AA6W-P5HJ.

Taylor, Jo et al., *Masculinising and feminizing hormone interventions for adolescents experiencing gender dysphoria or incongruence: a systematic review*, Archives of Disease in Childhood (Apr. 9, 2024), https://perma.cc/SCB7-HWAP.

Terhune, Chad et al., *As more transgender children seek medical care, families confront many unknowns*, Reuters (Oct. 6, 2022), https://perma.cc/D6KY-W9XA.

The Cass Review, Independent Review of Gender Identity Services for Children and Young People (Apr. 2024), https://perma.cc/J5GN-ELUY.

The Report of the 2015 U.S. Transgender Survey, National Center for Transgender Equality (Dec. 2017), https://perma.cc/L3Y4-GDMK.

Turban, Jack et al., *Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults*, 77 JAMA Psychiatry 68 (2020), https://perma.cc/4HYU-ZHM8.

Turban, Jack L. et al., *Psychological Attempts to Change a Person's Gender Identity From Transgender to Cisgender: Estimated Prevalence Across US States, 2015*, 109 Am. J. Pub. Health 1452 (2019), https://perma.cc/ZR7C-LWEM.

Turban, Jack, *I'm a Psychiatrist. Here's How I Talk to Transgender Youth and Their Families About Gender Identity.*, N.Y. Times (July 8, 2024), https://perma.cc/VY82-JWVW.

Twenge, Jean M. et al., *Increases in Self-identifying as Transgender Among US Adults, 2014–2022*, Sexual Rsch. & Soc. Pol'y, (July 13, 2024), https://perma.cc/YX3T-9HPJ.

Wittlin, Natalie M. et al., *Mental Health of Transgender and Gender Diverse Youth*, 19 Ann. Rev. Clinical Psych. 207 (2023), https://perma.cc/868B-XF59

Wright, Jason D. et al., *National Estimates of Gender-Affirming Surgery in the US*, JAMA Network Open (Aug. 23, 2023), https://perma.cc/P9AW-YMTB.

Exhibit 1

CV of Dr. Andrew Clark

Andrew Clark, M.D.

Telephone: 801-960-2138
Fax: 617-830-7281
Email: Andrewclark@andrewclarkmd.com

Board Certified, Adult, Child and Forensic Psychiatry
American Board of Psychiatry and Neurology

10 Concord Ave
Cambridge, MA 02138

Curriculum Vitae
October 25, 2023

Experienced forensic psychiatrist, currently in full time private practice in Cambridge, MA. Board certified in Psychiatry, Child and Adolescent Psychiatry, and Forensic Psychiatry.

Academic Training:

6/1981 B.S.	Carleton College, Northfield, MN; Magna Cum Laude, Biology
6/1982 C.T.S.	Pacific School of Religion (Graduate Theological Union), Berkeley, CA; Certificate of Theological Studies
6/1986 M. D.	University of Michigan Medical School, Ann Arbor, MI

Post-Graduate Training:

7/1986 - 5/1987	Resident in Family Practice, San Francisco General Hospital, San Francisco, CA
7/1987 - 6/1990	Resident in Pediatrics, Boston City Hospital, Boston, MA
7/1991 - 6/ 1994	Resident in Psychiatry, Massachusetts General Hospital, Boston, MA
7/1994 - 6/1996	Resident in Child and Adolescent Psychiatry, Massachusetts General Hospital, Boston, MA
9/2012 - 6/2013	Fellow, Infant Parent Mental Health Post-Graduate Certificate, University of Massachusetts, Boston, MA

Board Certifications:

10/1995	Board Certified in Psychiatry, American Board of Psychiatry and Neurology, #41372
10/1996	Board Certified in Child and Adolescent Psychiatry, American Board of Psychiatry and Neurology, #4170

4/2016	Subspecialty certification in Forensic Psychiatry, American Board of Psychiatry and Neurology, #732
1/1990 - 11/1997	Board Certified in Pediatrics, American Board of Medical Specialties, #44179 (now lapsed)

Academic Appointments:

7/1996 - 6/2016	Instructor in Psychiatry, Part-time, Harvard Medical School, Cambridge, MA
7/1996 - 6/2016	Clinical Associate in Psychiatry, Massachusetts General Hospital, Boston, MA
9/11/2017 – present	Assistant Professor of Psychiatry, Boston University School of Medicine

Forensic Experience:

10/1995-4/2001	Member, Department of Mental Health Child and Adolescent Forensic Consultation Team.
7/1996-6/1998	Staff Psychiatrist, Boston Juvenile Court Clinic, Boston, MA
9/1998-4/2003	Consulting Psychiatrist, Norfolk County Juvenile Court Clinic, Dedham, MA
7/1996-5/2005	Staff Psychiatrist, Children and the Law Program, Massachusetts General Hospital,
5/2005-9/2012	Medical Director, Children and the Law Program, Massachusetts General Hospital, Boston, MA Boston, MA

Have been retained as an expert in psychiatry or child psychiatry in over 75 civil cases, for both plaintiffs and defense.

Have been retained as an expert in psychiatry or child psychiatry in over 75 criminal cases.

Have served as court appointed Guardian ad litem in over 100 cases of contested custody.

Have been retained multiple times by defense counsel in the mitigation phase of capital trials.

Hospital Appointments or Other Employment:

7/1994-11/2010	Director of Psychiatric Services, South Bay House of Correction, Boston, MA
7/1996-12/2015	Private Practice of Child, Adult and Forensic Psychiatry, Cambridge, MA
5/2007-5/2009	Trainer (for incoming social workers), Department of Children and Families (DCF), Family Mental Health, Boston, MA
9/2008-8/2014	Case reviewer, Massachusetts Board of Registration in Medicine, Wakefield, MA
5/2012-4/2016	Medical Director, Children's Charter Trauma Clinic, Waltham, MA
9/11/2017- 5/2022	Director of Medical Student Education, Department of Psychiatry, Boston University School of Medicine.
9/11/17 -3/1/2020	Attending psychiatrist, Boston Medical Center
6/01/2018- 3/1/2020	Chief of Outpatient Psychiatry, Boston Medical Center

Honors:

6/1981	Magna Cum Laude, Carleton College, Northfield, MN
61981	Phi Beta Kappa, Carleton College, Northfield, MN
6/1989	Outstanding Teacher Award, Department of Pediatrics, Boston City Hospital, Boston, MA
6/1990	Neighborhood Health Center Outstanding Clinician Award, Department of Pediatrics, Boston City Hospital, Boston, MA
9/1992	Charter Leadership Fellow, American Academy of Child and Adolescent Psychiatry
9/1995	Resident Fellow, American Psychoanalytic Association
5/1996	Works in Progress Award, New England Council of Child and Adolescent Psychiatry, "Fathers in Jail" (unpublished paper)

Licensure and Certification:

2/1990	Massachusetts Medical License #72153
5/2016 - 2019	California Medical License #G142926
10/1995- 5/2002	Designated Forensic Psychiatrist, Massachusetts Department of Mental Health, Boston, MA

Teaching Experience and Responsibilities:

2005-2015	Taught an 8-week seminar series, Introduction to Forensic Child Psychiatry, to incoming child psychiatry fellows at the Massachusetts General Hospital, Boston, MA
1996-2014	Taught in the Forensic Psychology Seminar series offered through the

	Law and Psychiatry Service at Massachusetts General Hospital, Boston, MA
2018-2022	Director, Human Behavior in Medicine course for first year students, Boston University School of Medicine
2019-2022	Co-director, Drx Psychiatry course for second year students, Boston University School of Medicine
2017-2022	Director of the Psychiatry Clerkship, Boston University School of Medicine.
2017 – present	Co-teach a seminar on Forensic Psychology and Psychiatry to psychology interns in the Center for Multicultural Training in Psychology, Boston University.

Major Mentoring Activities:

7/1996- 6/2012	Supervision of two post-doctoral psychology fellows each year through the Children and the Law Program's fellowship in child forensic psychology at Massachusetts General Hospital, Boston, MA
7/1996- 12/2015	Supervision of two child psychiatry fellows in long-term psychotherapy through the Massachusetts General Hospital/Harvard Medical School training program in Child Psychiatry, Boston, MA
9/2017 – 5/2022	Long term supervision of a psychiatry resident at Boston Medical Center.

Other Professional Activities:

Professional Societies: Memberships, Offices, and Committee Assignments:

1996	Member, American Academy of Child and Adolescent Psychiatry
2000	Member, American Academy of Psychiatry and the Law
2000	Member, Massachusetts Medical Society
2004	Member, Association of Family and Conciliation Courts
2009	Member, Massachusetts Association of Guardian ad litems

Conference Presentations

Regional/Local:

1998	"Special Problems in Rogers and Commitment Cases", Flaschner Judicial Institute, Mental Health Legal Advisors Committee, Boston, MA
1999	"Girls and Violence: Trauma and Delinquency", Department of Social Services Training, Northampton, MA
2000	"Forensic Issues in Child and Adolescent Psychopharmacology",

Massachusetts General Hospital Continuing Education Course, Boston, MA

2000 "Overview of Psychopharmacology", Massachusetts Trial Court, Probation Training Seminar, Westborough, MA

2001 "The Role of the Psychiatrist in Dangerousness Evaluations of Juveniles", Suffolk University Juvenile Justice Conference, Boston, MA

2002 "Forensic Issues in Pediatric and Adolescent Psychopharmacology", Massachusetts General Hospital Psychopharmacology Seminar Series, Boston, MA

2002 "Child Abuse and Neglect: Dealing with the System", Bunker Hill Health Center, Massachusetts General Hospital, Charleston, MA

2002 "Child Diagnoses and the Labels We Use", Flaschner Judicial Institute, Children's Justice Act Workshop, Boston, MA

2002 "Understanding Needs and Accessing Services for Children with Mental Health Needs", Suffolk University Law School/Boston University School of Law, Boston, MA

2003 "Recent Developments in Psychopharmacology", Mental Health Legal Advisers Committee Training Conference for Probate Court Judges, Worcester, MA

2005 "Custodial Issues with Impaired Parents", MCLE Annual Family Law Conference, Wellesley, MA

2006 "Effective Therapies for Behaviorally Disturbed Children", Mental Health Legal Advisors Committee Conference, Boston, MA

March 20, 2009 "Implications of Domestic Violence and other Traumatic Stressful Events on Young Children", Massachusetts General Hospital Academy Child and Adolescent Psychiatry CME Course, Boston, MA

May 10, 2010 Faculty Member, Guardian ad Litem Training Program, Probate and Family Court Department, Boston, MA

June 10, 2011 "Bullying and Harassment: From the Schoolyard to the Internet", Mental Health Legal Advisors Committee Seminar, Boston, MA

September 21, 2011 "Removal: Are We There Yet?", Massachusetts Bar Association Continuing Legal Education Seminar, Boston, MA

October 1, 2010 "The Myth of Neutrality: Recognizing Bias in GAL Evaluations", Panel Discussant, Massachusetts Association of Guardians ad litem, Wellesley, MA

January 27, 2012 "Managing Ethical and Legal Dilemmas in School Mental Health", School Mental Health Conference, Harvard Medical School Department of Continuing Education, Cambridge, MA

November 7, 2014 "High Conflict Behavior in Family Law Cases", Panel Discussant, Massachusetts Association of Guardians ad litem, Wellesley, MA

March 12, 2020 "The Psychiatrist's Role in Capital Punishment Cases". Grand Rounds, Department of Psychiatry, Boston Medical Center, Boston, MA

National:

November 29, 2012 "Psychopharmacology of Preschoolers and Toddlers", National Training Institute, Zero to Three, Los Angeles, CA

Bibliography:

ORIGINAL PEER REVIEWED ARTICLES:

Clark, A: Is Juvenile Solitary Confinement a Form of Child Abuse? J Am Acad Psych Law. 45 (350-57) 2017.

Clark, A: Psychiatric Diagnoses and Informed Consent. The Journal of Clinical Ethics 29 (No 2) Summer 2018. 93-99.

EDITORIAL AND CRITICAL REVIEWS:

Clark, A, Herman J, Schlozman, S, Beresin, E: False Accusations Against Residents: A Training Program's Perspective. Academic Psychiatry 2011; 35: 215-216

Clark, A: In Her Wake: A Child Psychiatrist Explores the Mystery of Her Mother's Suicide. Family Court Review, 49: 4: 860-861, Oct 2011.

TEXTBOOK CHAPTERS:

Clark, A., Jellinek, M. Posttraumatic stress disorder in adolescents. In Comprehensive Adolescent Health Care, 2nd Edition, St. Louis: Mosby, 1998.

Clark, A, Jellinek, M: Posttraumatic Stress Disorder. In Saunders Manual Of Pediatric Practice, Philadelphia, Saunders, 1998.

Clark, A. (2014). Parenting through the digital revolution. In F. Saleh, A. Grudzinkas & A. Judge (Eds.) Adolescent sexual behavior in the digital age. (pp 247-261). Oxford University Press